

10652

CERTIFICATE OF DEATH

Reg. Dist. No.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Bushwood		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Bushwood - rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Matthew		First Roosevelt		Middle Bailey		Last Sept.		4. DATE OF DEATH Month 24		Day 19		Year 59	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1875		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James H. Bailey		14. MOTHER'S MAIDEN NAME Julia C. Russell											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 217-32-2994		INFORMANT Mrs. Catherine Bailey, Bushwood, Maryland		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive heart failure DUE TO (b) Coronary occlusion DUE TO (c) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 20 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mechanicsville, Maryland		(County)		(State)			
21. I certify that I attended the deceased from July 1955 , 19____, to Sept 1959 , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above ADDRESS (Street, city or town, state) Leon W. Berube, Mechanicsville, Maryland		DATE SIGNED Leon W. Berube											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/59		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) Bushwood, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley, Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 26 '59		24b. REGISTRAR'S SIGNATURE							

OFF. COPY

Mr. Harry

Wm. H. Harrison - 1891

Wm. H. Harrison - 1891

Wm. H. Harrison - 1891

Wm. H. Harrison - 1891

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Wm. H. Harrison - 1891

Wm. H. Harrison - 1891

10653

CERTIFICATE OF DEATH

Reg. Dist. No. 10636

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b X Oakley			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital				d. STREET ADDRESS 1 Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Dent Last Burch				4. DATE OF DEATH Month Sept. Day 3 Year 19 59			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/30/1890		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph H. Dent				14. MOTHER'S MAIDEN NAME Francis L. Dent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Elliott E. Burch - Oakley, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: Acute cardiac decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypopotassemia, uremia DUE TO (c) Arteriosclerotic CV dis							INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, arthritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan , 19 48 , to Sept 3 , 19 59 , that I last saw the deceased alive on Sept 3 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED 9/4/59							
ACTUAL SIGNATURE J. Roy Guyther				M.D. Mechanicsville, Md.			
PHYSICIAN'S NAME (Type) J. Roy Guyther, MD				Mechanicsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/59		22c. NAME OF CEMETERY OR CREMATORY All Saint, s		22d. LOCATION (City, town, or county) (State) Oakley, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10637

10654

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First James Alexandra Middle Countis Last Countis				4. DATE OF DEATH Month Sept Day 20 Year 1959			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1944		9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Day		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph I. Countis				14. MOTHER'S MAIDEN NAME Mary Ellen Countis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph I. Countis Address Leonardtwn, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH IMMED	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DROWNED IN FARM POND					
20c. TIME OF INJURY Month, Day, Year Hour 4:00 p. m. SEPT 20 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) (County) (State) LEONARDTOWN MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William D. Boyd M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 9/22/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/59		22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		24a. REC'D BY REGISTRAR SEP 25 '59	
				24b. REGISTRAR'S SIGNATURE William D. Boyd			

FOR STATE
HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF DEATH: _____

5. TIME OF DEATH: _____

6. PLACE OF DEATH: _____

7. OCCUPATION: _____

8. CAUSE OF DEATH: _____

9. MANNER OF DEATH: _____

10. SIGNATURE OF EXAMINER: _____

11. SIGNATURE OF WITNESS: _____

12. SIGNATURE OF CORONER: _____

13. SIGNATURE OF JURY: _____

14. SIGNATURE OF JUDGE: _____

15. SIGNATURE OF CLERK: _____

16. SIGNATURE OF NURSE: _____

17. SIGNATURE OF DOCTOR: _____

18. SIGNATURE OF PHARMACEUTICAL: _____

19. SIGNATURE OF LABORATORY: _____

20. SIGNATURE OF OTHER: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH


10638

10655

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 3yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Aloysius Last Countis				4. DATE OF DEATH Month Sept Day 20 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1941		9. AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min.	IF UNDER 24 HRS. Months 18 Days 18 Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. SA.	
13. FATHER'S NAME Joseph I. Countis				14. MOTHER'S MAIDEN NAME Mary Ellen Curtis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Joseph I. Countis Leonardtown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO						INTERVAL BETWEEN ONSET AND DEATH IMMED	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DROWNED IN FARM POND					
20c. TIME OF INJURY Month, Day, Year 4:00 p.m. SEPT 20 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) (County) (State) LEONARDTOWN ST MARYS MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd M.D.		DATE SIGNED 9/22/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/59		22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR DATE SEP 25 '59		24b. REGISTRAR'S SIGNATURE C. Clark & Sons	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10639

Reg. Disf. No.

10655

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood		c. LENGTH OF STAY IN 1b X Lexington Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RHODA W. ELLIOTT		4. DATE OF DEATH Month Sept. Day 12 Year 1959	
5. SEX F	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1929
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Graves		14. MOTHER'S MAIDEN NAME Fannie Loveless	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT James R. Elliott-		Address 353 - 5th Street Rankin, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broken neck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death: immed.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was passenger in auto which hit electric pole	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4:40 7-12-59	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VISTA Rd	20f. (City or town) (County) (State) Hollywood St Marys Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm D Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Wm. D. Boyd MD		DATE SIGNED 9/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/16/59	22c. NAME OF CEMETERY OR CREMATORY Gladys, Virginia	22d. LOCATION (City, town, or county) (State) Gladys, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson- Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE SEP 16 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10640

Reg. Dist. No.

10657

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Holly				4. DATE OF DEATH Month Sept. Day 27 Year 19 59			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 3, 1900		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Leonardtwn Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshuaa Milds				14. MOTHER'S MAIDEN NAME Sarah J. Ashton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Aloysius Holly		Address Leonardtwn, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Fracturing Injuries 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HIT BY AUTO					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2:30 9-27 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ROUTE #5		20f. (City or town) (County) (State) LEONARDTOWN ST MARYS MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W.D. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/30/59	
EXAMINER'S NAME (Type) William D. Boyd. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/59		22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtwn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		24a. REC'D BY REGISTRAR 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10641

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's 10658 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell c. LENGTH OF STAY in 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Abell d. STREET ADDRESS Abell e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thurston Wilbert Jameson			4. DATE OF DEATH Month Day Year Sept. 23, 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		
8. DATE OF BIRTH Feb. 2, 1911		9. AGE (in years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Philip Jameson			
14. MOTHER'S MAIDEN NAME Sadie Jameson Filmore			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. none			17. INFORMANT Address Edward Jameson Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUN SHOT (IN NECK) DUE TO (b) 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SELF INFLICTED 2 SHOTGUN INTERVAL BETWEEN ONSET AND DEATH IMMED.						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SELF INFLICTED 2 SHOTGUN				
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 9-23-59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) AT HOME		
20f. (City or town) ABELL		(County) ST. MARY'S		(State) MD		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Wm D Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/24/59		
EXAMINER'S NAME (Type) William D. Boyd M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/59		22c. NAME OF CEMETERY OR CREMATORY All Saints		
22d. LOCATION (City, town, or county) Oakley,		(State) Md.		24a. REC'D BY REGISTRAR DATE OCT 1 '59		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus		

1004

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

10038

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature.

NAME: [Blank]
AGE: [Blank] SEX: [Blank] RACE: [Blank]
OCCUPATION: [Blank]
CAUSE OF DEATH: [Blank]
SIGNATURE: [Blank]



Vertical text on the right margin, likely a filing or processing stamp.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10643

10659

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 30min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First William Middle Joseph B. Last Mattingly				4. DATE OF DEATH Month September Day 12 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1942		9. AGE (in years last birthday) 17 yrs.	IF UNDER 1 YEAR Months 2 Days 10	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School boy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bertram Mattingly				14. MOTHER'S MAIDEN NAME Mary Agnes Welch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address William B. Mattingly Leonardtown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Traumatic Amputation left leg DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 30 min 30 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit light pole with auto & was thrown out					
20c. TIME OF INJURY Month, Day, Year 12:28 p.m. 9-12 1959		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rout 245		20f. (City or town) (County) (State) Leonardtwn St Marys Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W.D. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William D. Boyd M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/59		22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtwn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR SEP 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

10660

CERTIFICATE OF DEATH

10644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sharon Middle Lee Last Nelson		4. DATE OF DEATH Month Sept. Day 18, Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1955
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 18 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY Michigan	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Edward Nelson		14. MOTHER'S MAIDEN NAME Elizabeth Gene Poe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT None		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis Pneumonia 587.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Cystic Fibrosis of Pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 wks 4 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 15 , 19 57 , to Sept 18 , 19 59 , that I last saw the deceased alive on Sept 18 , 19 59 , and that death occurred at 8:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtwn DATE SIGNED 9/21/59			
ACTUAL SIGNATURE W.D. Boyd M.D.		PHYSICIAN'S NAME (Type) William D. Boyd M.D. Leonardtwn, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/59	
22c. NAME OF CEMETERY OR CREMATORY St George Island Methodist		22d. LOCATION (City, town, or county) (State) St. George Island, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland	
24a. REC'D BY REGISTRAR SEP 25 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

1000

CERTIFICATE OF DEATH

1000

1000

1000

1000

Transcribed from original
of the Bureau of Census

1000

CERTIFICATE OF DEATH

Reg. Dist. No. **10645****10661**

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville				c. LENGTH OF STAY IN 1b 17 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Richard Last Quade				4. DATE OF DEATH Month September Day 29 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1910	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard C. Quade				14. MOTHER'S MAIDEN NAME Alice Russell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579 07 9836			
INFORMANT H. Madeline Quade				Address Mechanicsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of undetermined origin DUE TO (b) With generalized metastasis DUE TO (c) proved by biopsy of lung- 199.2 Interval between onset and death 10 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 1 , 19 58 , to Sept 28 , 19 59 , that I last saw the deceased alive on Sept 15 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md DATE SIGNED 10/3/59 ACTUAL SIGNATURE J. Roy Guyther M.D. PHYSICIAN'S NAME (Type) J. Roy Guyther M.D. Mechanicsville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/2/59		22c. NAME OF CEMETERY OR CREMATORY St. Joseph	
22d. LOCATION (City, town, or county) (State) Morganza, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		24a. REC'D BY REGISTRAR DATE OCT 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur & Anna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL OF DEATH

1901

MAINTAINED STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF BIRTH: _____

PLACE OF DEATH: _____

Cause of Death: _____

Signature: _____

Official: _____

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10662 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u>		c. LENGTH OF STAY IN 1b <u>5yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Lynwood</u> Last <u>Short</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1948</u>		9. AGE (In years last birthday) <u>11yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis T. Dade</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Helen Short</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Margaret H. Young</u> Address <u>Leonardtwn, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DROWNED IN FARM POND</u>			
20c. TIME OF INJURY Month, Day, Year <u>4:00</u> a. m. <u>SEPT 20</u> 19 <u>59</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>FARM</u>	20f. (City or town) (County) (State) <u>LEONARDTOWN ST MARYS MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William D. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/22/59</u>	
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		22d. LOCATION (City, town, or county) (State) <u>Leonardtwn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtwn, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton E. Kline</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 ~~1~~
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10647

CERTIFICATE OF DEATH

Reg. Dist. No.

10663

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Drayden		c. LENGTH OF STAY IN lb 8 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Drayden		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Winfield Last Slusser		4. DATE OF DEATH Month September Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1917
9. AGE (In years lost birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 19 Hours 19 Min.	IF UNDER 24 HRS. Months 41 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel & Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Lexington, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry C. Slusser		14. MOTHER'S MAIDEN NAME Bertha C. Daniel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11 227-07-3970	
17. INFORMANT Mrs Enid G. Slusser Drayden, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Coronary sclerosis (c) 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus and gout			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October, 1956 to Sept 19, 1959 , that I last saw the deceased alive on Sept 18, 1959 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P.J. Bean M.D.		ADDRESS (Street, city or town, state) Great Mills, Maryland	
DATE SIGNED 9/20/59			
PHYSICIAN'S NAME (Type) P.J. Bean M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/59	
22c. NAME OF CEMETERY OR CREMATORY St. George Episcopal		22d. LOCATION (City, town, or county) (State) Valley Lee, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland	
24a. REC'D BY REGISTRAR SEP 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10001

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

10001

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of attending physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

12. Place of registration: _____

13. Name of registrar: _____

14. Signature of registrar: _____

15. Date of registration: _____

16. Place of registration: _____

17. Name of registrar: _____

18. Signature of registrar: _____

19. Date of registration: _____

20. Place of registration: _____

21. Name of registrar: _____

22. Signature of registrar: _____

23. Date of registration: _____

24. Place of registration: _____

25. Name of registrar: _____

26. Signature of registrar: _____

27. Date of registration: _____

28. Place of registration: _____

29. Name of registrar: _____

30. Signature of registrar: _____

31. Date of registration: _____

32. Place of registration: _____

33. Name of registrar: _____

34. Signature of registrar: _____

35. Date of registration: _____

36. Place of registration: _____

37. Name of registrar: _____

38. Signature of registrar: _____

39. Date of registration: _____

40. Place of registration: _____

41. Name of registrar: _____

42. Signature of registrar: _____

43. Date of registration: _____

44. Place of registration: _____

45. Name of registrar: _____

46. Signature of registrar: _____

47. Date of registration: _____

48. Place of registration: _____

49. Name of registrar: _____

50. Signature of registrar: _____

51. Date of registration: _____

52. Place of registration: _____

53. Name of registrar: _____

54. Signature of registrar: _____

55. Date of registration: _____

56. Place of registration: _____

57. Name of registrar: _____

58. Signature of registrar: _____

59. Date of registration: _____

60. Place of registration: _____

61. Name of registrar: _____

62. Signature of registrar: _____

63. Date of registration: _____

64. Place of registration: _____

65. Name of registrar: _____

66. Signature of registrar: _____

67. Date of registration: _____

68. Place of registration: _____

69. Name of registrar: _____

70. Signature of registrar: _____

71. Date of registration: _____

72. Place of registration: _____

73. Name of registrar: _____

74. Signature of registrar: _____

75. Date of registration: _____

76. Place of registration: _____

77. Name of registrar: _____

78. Signature of registrar: _____

79. Date of registration: _____

80. Place of registration: _____

81. Name of registrar: _____

82. Signature of registrar: _____

83. Date of registration: _____

84. Place of registration: _____

85. Name of registrar: _____

86. Signature of registrar: _____

87. Date of registration: _____

88. Place of registration: _____

89. Name of registrar: _____

90. Signature of registrar: _____

91. Date of registration: _____

92. Place of registration: _____

93. Name of registrar: _____

94. Signature of registrar: _____

95. Date of registration: _____

96. Place of registration: _____

97. Name of registrar: _____

98. Signature of registrar: _____

99. Date of registration: _____

100. Place of registration: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

10648

10664

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b 7 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Clarence Woodburn				4. DATE OF DEATH Month Day Year September 23, 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1884		9. AGE (In years lost birthday) yrs. 74	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George M. Woodburn				14. MOTHER'S MAIDEN NAME Sarah M. Canter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577 09 9298			
INFORMANT Elizabeth R. Wood				Address Indian Head, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Originating probably from the Gall bladder DUE TO (c) the Gall bladder							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Leonardtown				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 8:30 , 19 59 , to 9:23 , 19 59 , that I last saw the deceased alive on 9:23 , 19 59 , and that death occurred at 2:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Abdussamed Samadi M.D. Leonardtown, Maryland DATE SIGNED 9-26-59							
ACTUAL SIGNATURE A. Samadi							
PHYSICIAN'S NAME (Type) Abdussamed Samadi M.D. Leonardtown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/59		22c. NAME OF CEMETERY OR CREMATORY Old Field		22d. LOCATION (City, town, or county) (State) Hughesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 1 '59	
						24b. REGISTRAR'S SIGNATURE Arthur E. Hance	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10000

1

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and location.]